IN THE MATTER OF	*	**BEFORE THE**
LISA A. MORGAN, P.T.A.	*	**STATE BOARD OF**
RESPONDENT	*	**PHYSICAL THERAPY EXAMINERS**
LICENSE No.: A2697	*	**CASE No.: 11-07**

* * * * * * * * * * * * * *

CONSENT ORDER

On September 20, 2011, the State Board of Physical Therapy Examiners (the "Board") charged Lisa A. Morgan, P.T.A. (the "Respondent") (D.O.B. 05/2/1972), license number A2697, with violating the Maryland Physical Therapy Act (the "Act") codified at Md. Health Occ. Code Ann. § 13-101, *et seq.*, ("the Act") (2009 Repl. Vol.).

The pertinent provisions of the Act under § 13-316 provide the following:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, reprimand any licensee or certificate holder, or suspend or revoke a license or a restricted license if the applicant, licensee, or holder:
>
> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;
>
> (15) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy;

The specific regulations under which the Board charged Respondent are as follows:

COMAR 10.38.03.02 (B)(1)(b)

(1) The physical therapist assistant shall:

(b) Exercise sound judgment and adequate care in the performance of duties;

COMAR 10.38.03.02 (B)(1)(g)

(1) The physical therapist assistant shall:

(g) Document ongoing communication regarding changes in a patient's status and treatment authorized by the physical therapist;

COMAR 10.38.03.02-1(C)

The physical therapist assistant shall document the patient's chart each time the patient is seen by the physical therapist assistant following the physical therapist's initial evaluation or reevaluation by including the following:

(1) Date;
(2) Cancellation and no shows;
(3) Modalities, procedures, or both, including parameters involved, and areas of body treatment;
(4) Objective Status;
(5) Response to treatment, if any;
(6) Continuation of plan as established by the physical therapist or change of plans as authorized by the physical therapist; and
(7) Signature, title (PTA), and license number, although the flow chart may be initialed.

On October 18, 2011, a Case Resolution Conference was held before a committee of the Board. As a result of negotiations, the parties have agreed to resolve the Board's charges as follows:

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was licensed as a physical therapy assistant in the State of Maryland. Respondent was initially licensed to practice

on October 2, 2002, having been issued license number A-2697. Respondent last renewed her license on May 17, 2011, which will expire on May 31, 2013.

2. At all times relevant hereto, Respondent was employed at a for-profit nursing and rehabilitation center (the "Center") with approximately 100 beds, in southern Maryland. The Center provides onsite physical therapy services to the residents of the Center.

3. Respondent was employed at the Center from October 2007 through July 30, 2010 as a licensed Physical Therapy Assistant ("PTA").

II. Complaint

4. On August 6, 2010 the Board received a complaint from the Nursing Home Administrator of the Center concerning Respondent. The complaint stated that after receiving reports of "misutilization of best practices regarding treating patients and documentation of patient care," the Center conducted an internal investigation consisting of chart reviews, and resident and staff interviews. The internal investigation substantiated problems with Respondent's documentation of patient care. The Center terminated Respondent as a result of its investigation.

5. Thereafter, the Board opened the case for investigation.

III. The Board's Investigation

6. On September 7, 2010, the Board's investigator subpoenaed copies of the Respondent's personnel file from the Center. Respondent's personnel file contained documentation from the Center's internal investigation which led to the termination of Respondent.

7. On September 24, 2010, the Board's investigator issued a subpoena to the Center for the eight (8) patient charts which were reviewed and referenced in the Center's investigation.

8. On October 6, 2010 the Board received the patient records and sent the records, the complaint, and other documents to an expert in physical therapy for review.

9. On March 1 and 4, 2011 the Board's investigator interviewed two of the physical therapists from the Center.

10. On March 3, 2011, Respondent was interviewed at the Board's offices.

IV. The Center's Internal Investigation

11. According to the personnel file, from July 27 through 30, 2010, the Area Rehabilitation Manager for the Center conducted an internal investigation in response to several complaints from the physical therapy staff that Respondent was improperly copying and pasting patient progress notes; thereby producing inaccurate patient records. Chart audits and staff interviews were completed during this investigation.

12. According to the personnel file, on February 19, 2010, Respondent was counseled by the Area Rehabilitation Director for the Center, for failure to meet appropriate standards of patient record keeping at the Center.

13. According to Respondent's personnel file, from mid February through mid May 2010, an audit of patient treatment records revealed that Respondent re-created original patient treatment notes on a consistent basis.

14. On July 27, 2010, the Nursing Home Administrator and the Area Rehabilitation Manager met with Respondent. Respondent admitted to copying and pasting or otherwise re-using patient progress notes on multiple occasions.

15. On July 30, 2010, Respondent was terminated from the Center for improperly copying and pasting patient progress notes. The internal investigation concluded that the Respondent was not "utilizing best clinical practices, as well as not accurately documenting resident progress in her daily notes". This resulted in one of the Physical Therapists of the Center incorrectly treating a patient based on Respondent's inaccurate documentation of the patient's ambulatory status.

V. Patient Specific Findings Based on Expert Review of the Treatment Records

Patient 1[1]

16. Patient 1 participated in physical therapy at the Center from November 16, 2009 to June 24, 2010 due to difficulty walking. Patient 1 received physical therapy on 135 occasions, 105 of which were provided by Respondent.

17. Respondent copied and pasted treatment notes for Patient A from two different physical therapists, either exactly or with minimal changes[2] in 60 of 105 visits (over 50%).

18. For example, between November 30, 2009, and December 17, 2009, in 14 consecutive notes, Respondent copied a physical therapist's note of November 28, 2009, either verbatim or with minimal changes.

19. In another example, on January 28, 2010, Respondent copied a physical therapists note from January 27, 2010, verbatim, and then added only one original

[1] Patient names are confidential and are not used in the Consent Order. Respondent has been provided a Confidential Patient Identification List.

[2] "Minimal Changes" indicates a situation where only a few words of original text were added or only slight adjustment of exercise distances or times were made in the body of the note.

sentence to the end of the "objective" section. Respondent then reused this note from January 28, 2010 on nine consecutive visits from January 29, 2010 through February 9, 2010. All four sections of the treatment note were identical for all of the visits.

20. In June of 2010, Respondent began alternating between two treatment notes[3], using the same one on Mondays, Wednesdays and Fridays and another one for both Tuesdays and Thursdays.

Patient 2

21. Patient 2 participated in physical therapy at the Center from January 15, 2010 through March 2, 2010 due to difficulty walking and joint pain. Patient 2 received physical therapy on 34 visits, 25 of which were provided by Respondent.

22. Respondent copied and pasted treatment notes for Patient 2 from two different physical therapists, either exactly or with minimal changes in 13 of 25 visits (52%).

23. For example, Respondent repeated verbatim the same treatment note that a physical therapist wrote on January 23, 2010, on five visits from January 25 through 29, 2010. This included the exact repetition of a statement from Patient 2 that she "aches all over."[4]

Patient 3

24. Patient 3 participated in physical therapy at the Center from June 23, 2010 through July 20, 2010 for gait training due to an unspecified debility. Patient 3 received physical therapy for a total of 12 visits, 7 of which were provided by Respondent.

[3] Minimal changes, if any, were made between the iterations of the treatment notes.

[4] This note was copied with minimal additions from a physical therapist's treatment note on January 23, 2010.

25. Respondent copied and pasted treatment notes for Patient 3 either exactly or with minimal changes in 5 of 7 visits (71%).

26. For example, Respondent copied and pasted the same treatment note for July 12, 13, 15, and 19, 2010 with minimal changes.

Patient 4

27. Patient 4 participated in physical therapy at the Center from May 10, 2010 through July 20, 2010 due to generalized muscle weakness. Patient 4 received physical therapy for a total of 40 visits, 17 of which were provided by Respondent.

28. Respondent copied and pasted treatment notes for Patient 4 either exactly or with minimal changes in 7 of 17 visits (41%).

29. For example, Respondent repeated her treatment note from June 10 on June 16, 2010, and her treatment note from June 11 on June 14, 2010.

30. Respondent copied a physical therapist's treatment note from June 6 verbatim in her treatment note on June 7, 2010.

Patient 5

31. Patient 5 participated in physical therapy at the Center from January 26, 2010 through March 1, 2010 due to a leg abscess and generalized muscle weakness. Patient 5 was seen again from June 26, 2010 through July 1, 2010 due to an above-the-knee leg amputation and generalized muscle weakness. Patient 5 received physical therapy for a total of 25 visits, 13 of which were provided by Respondent.

32. Respondent copied and pasted treatment notes for Patient 5 either exactly or with minimal changes in 9 of 13 visits (69%).

33. On February 17, 2010, Respondent copied the same grammatical error of the addition of a comma from the January 16, 2010 entry which incorrectly stated, "lying with modA,/Max A pt. performs..."

34. In another example, Respondent repeated verbatim her treatment note from June 28, 2010 on June 29 and 30 and made only minimal changes to her treatment note on July 1, 2010.

Patient 6

35. Patient 6 participated in physical therapy at the Center from October 1, 2009 through December 4, 2009 due to difficulty walking. Patient 6 was seen again from May 18, 2010 through August 7, 2010 due to a bone fracture and difficulty walking. Patient 6 received physical therapy for a total of 83 visits, 52 of which were provided by Respondent.

36. Respondent copied and pasted treatment notes for Patient 6 either exactly or with minimal changes in 43 of 52 visits (83%).

37. For example, on October 6, 2009, Respondent copied a note which was written by a physical therapist on October 5, 2009.

38. Between October 19, 2009 and December 3, 2009, on 22 visits, Respondent copied verbatim a note which was written by a physical therapist. These verbatim notes were repeated even though other physical therapists had completed different treatments in between these dates.

39. In another example, Respondent copied verbatim her treatment note from May 20, 2010 on May 21, 2010 including the fact that "patient then began throwing up when sitting at rest."

40. Respondent also copied a physical therapist's treatment note from June 4, 2010 and pasted it with minimal changes on June 8, 11, 16, 17, and 18, 2010.

41. There were multiple grammatical errors in the notes which Respondent copied in the successive notes.

Patient 7

42. Patient 7 participated in physical therapy at the Center from December 21, 2009 through January 28, 2010 due to an unspecified debility. Patient 7 was seen again from May 4, 2010 through May 31, 2010 due to difficulty walking. Patient 7 received physical therapy for a total of 43 visits, 25 of which were provided by Respondent.

43. Respondent copied and pasted treatment notes for Patient 7 either verbatim or with minimal changes in 21 of 25 visits (84%).

44. For example, Respondent copied a physical therapist's "objective" section from a December 23, 2009 treatment note and pasted it in her own treatment note for December 28 and 29, 2010.

45. Respondent also copied the physical therapist's treatment note from December 31, 2009 and "back pasted" it verbatim in her own treatment note for December 30, 2009.

46. Between January 21, 2010 and January 28, 2010, in five entries, Respondent copied the notes with the exact grammatical errors in all five notes.

47. Respondent copied the physical therapist's treatment note from May 19, 2010 and "back pasted" it verbatim in her own treatment note for May 18, 2009.

48. Between May 6, 2010, and May 21, 2010, in a total of 7 entries, Respondent copied verbatim, or with minimal changes an entry by the physical therapist on May 5, 2010.

Patient 8

49. Patient 8 participated in physical therapy at the Center from January 7, 2010 through March 22, 2010 due to difficulty walking. Patient 8 received physical therapy for a total of 50 visits, 34 of which were provided by Respondent.

50. Respondent copied and pasted treatment notes for Patient 8 either exactly or with minimal changes in 28 of 34 visits (82%).

51. For example, Respondent repeated the same treatment note verbatim for 15 consecutive visits from January 19, 2010 through February 10, 2010.[5] In each of these notes, Respondent repeated the phrase "poor carryover of safety instructions." Respondent did document communication with the physical therapist or explain the lack of carryover.

VI. Summary of Findings

52. Respondent's conduct as described above is evidence of making or filing a false report or record, in violation of H.O. § 13-316 (12); violating any rule or regulation adopted by the Board, in violation of H.O. § 13-316 (15); and failure to meet accepted standards in delivering limited physical therapy, in violation of H.O. § 13-316 (25), specifically COMAR 10.38.03.02 (B)(1)(b) and (g), and COMAR 10.38.03.02-1(C), in that:

[5] One number value was changed in the note on 2/9/2010 and then repeated on 2/10/10.

a. Respondent repeatedly copied by "cut and paste" previous notes written by physical therapists and notes she had written herself; thereby failing to fully and accurately document the chart each time the patient was seen;

b. On multiple occasions, Responded cut and pasted notes written on dates later than the date she provided the service;

c. Respondent failed to document ongoing communication with the primary physical therapists regarding changes in the patients' status and treatment authorized by the physical therapist; as well as the patients' progression or lack of progress toward treatment goals;

d. Respondent failed to exercise sound judgment in the performance of her duties;

e. Respondent's documentation had the potential to mislead the primary physical therapists that the patients were progressing or were performing activities sooner than expected; which created unsafe progression of the patients;

f. Respondent jeopardized the safety of the patients and jeopardized the care provided by the physical therapists for these patients;

g. In regard to Patient 7, Respondent made no mention of progress towards goals and on multiple visits instructed Patient 7 to ride a bike for approximately 50% of the session, without justification; and

h. In regard to Patient 8, Respondent failed to document communication with the supervising/primary physical therapists in regard to the treatment goals during the 15 visits in which she repeated the same concern verbatim.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent's conduct as set forth above constitutes, willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy, in violation of H.O. § 13-316 (12); violates any provision of this title or rule or regulation adopted by the Board; in violation of H.O. § 13-316 (15), and fails to meet accepted standards in delivering physical therapy or limited physical therapy, in violation of H.O. §

13-316(10) (25), specifically COMAR 10.38.03.02 (B)(1)(b) and (g), and COMAR 10.38.03.02-1(C).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 15TH day of NOVEMBER, 2011, by a majority of the Board considering this case:

ORDERED that Respondent is **REPRIMANDED**, and be it further

ORDERED that Respondent is placed on **PROBATION** for a minimum of **TWO (2) YEARS** from the date the Board executes this Consent Order, with the following terms and conditions:

1. Respondent shall enroll in and successfully complete the next available offering of the Maryland Physical Therapy Law and Ethics Course. Respondent shall submit proof of her successful completion of the course;

2. Within six (6) months of the date of this Consent Order, Respondent shall enroll in and successfully complete a Board-approved course in documentation. Respondent shall submit proof of her successful completion of the course;

3. The courses shall be in addition to any Continuing Education requirements mandated for continuing licensure;

4. Within three (3) months from the date of this Consent Order, and every three (3) months thereafter for the first year of probation, Respondent shall submit to the Board three (3) patient charts for review and audit. For the second year of probation, Respondent shall submit patient charts for review at the Board's discretion;

5. Respondent shall cooperate with the Board in the monitoring, supervising and investigating her compliance with the terms and conditions of this Consent Order;

6. Respondent's failure to fully cooperate with the Board shall be deemed a violation of the probationary terms and a violation of this Consent Order;

7. Respondent shall comply with the Maryland Physical Therapy Act and all laws, statutes and regulations pertaining thereto; and be it further

ORDERED that Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that if Respondent violates any of the terms and conditions of this Consent Order, the Board, after notice and an opportunity for a hearing and determination of a violation, may impose additional sanctions it deems appropriate, including revocation or suspension, and/or a monetary penalty authorized under the Maryland Physical Therapy Examiners Act; and be it further

ORDERED that after the conclusion of the entire **TWO (2) YEAR PROBATION**, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, will grant the termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol.).

11/15/2011
Date

John Baker, P.T., ~~D.P.T.~~ DScPT
Chairperson
Maryland State Board of Physical Therapy Examiners

CONSENT

I, Lisa A. Morgan, P.T.A., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order, voluntarily and without reservation, after having had an opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

11-9-11
Date

Lisa A. Morgan, P.T.A.

NOTARY

STATE OF Maryland

~~**CITY**~~**/COUNTY OF** St. Mary's

I HEREBY CERTIFY that on this 9 day of November, 2011, before me, a Notary Public of the foregoing State and City/County personally appear Lisa A. Morgan, P.T.A., License Number A2697, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Stacy L Wilson
Notary Public

My commission expires 11-24-2011